EAC PHASE I REPORT – COMMENTS ON DRAFT REPORT DISTRIBUTED 4/17/15

This document contains the following submitted by EAC members and other readers:

- A list of (29) recommendations considered by the EAC, plus (1) recommendation not previously considered but included in the draft report and (1) recommendation not in the draft report that was suggested after reading the draft report
- The status of each recommendation as of the EAC's initial consideration
- For those recommendations that the EAC tabled, a summary of why the EAC tabled it
- Comments, questions, and suggested edits to recommendations
- Proposed treatment at the 4/23 EAC meeting as an item on a consent agenda or as an item for discussion on the regular agenda

EAC Summarized Recommendations – Annotated with Council Comments for Discussion
April 23, 2015

Rec #	Recommendation	Status as of Initial EAC Review	Proposed Agenda Status for 4/23 EAC
1.1	**Patient Attestation**: Patients should be able, though not required, to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider's panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits.	Adopt with changes	Consent
1.2	**Patient Notification:** Patients should be made aware when they are attributed to a physician who is participating in a shared savings program. Notification should be in a manner that is accessible and understandable by all patients.	Adopt with changes	Regular
1.2	*Arlene Murphy (CAB): I have been trying to better understand how implementation and communication of prospective patient attribution will ensure that it is not perceived by consumers as a limitation on choice of provider. Would it be possible to add language to the EAC Recommendations making it clear that consumers will retain their right to choose or change provider? This language could be added to Recommendation 1.1, 1.2 or 5.1.*		
1.3	**Settings of Care for Attribution:** Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or urgent care center). For integrated ACOs (i.e.; an ACO that includes a hospital), payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage an organization to take	Table for further consideration	Regular

	accountability for their care. The use of a non-traditional setting of care to assign a patient to an organization will only be used if a patient does not have any visits with a primary care provider in the last year and/or did not designate a provider at the outset of the contract period. This recommendation is meant to provide an incentive at the macro level for an organization to develop the required care coordination structure and primary care access to improve care for the most difficult patients.		
1.3	*Summary of Prior EAC Discussion: Notion of attributing at-risk patients who require more coordination is desirable, but cognizant of the risk of overly burdening providers who are assigned these patients*		
1.3	*Kate McEvoy: I remain uncomfortable with the potential inclusion of ED as another setting of care for secondary attribution.*		
1.4	**Timing of Attribution:** Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment.	Adopt as presented	Regular
1.4	*Adam Stolz/Katie Sklarsky (Chartis): Change to "Prospective attribution provides a vehicle for generating provider and patient awareness… and provides a degree of protection against patient discontinuation." As originally written, the recommendation's tone is out of sync with that of the others and might lead a reader to conclude that prospective attribution is a full solution for this issue.*		
1.5	**Attribution Reconciliation:** An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year. In instances in which the retrospective reconciliation process determines that a patient should be un-attributed, that patient will not be re-attributed to another ACO.	Adopt with changes	Regular
1.5	*Kate McEvoy: The recommendation regarding "un-attribution" seems awkwardly framed. This could benefit from more discussion.*		
1.5	*Adam Stolz/Katie Sklarsky (Chartis): Merge 1.4 and 1.5 since 1.5 applies specifically when a prospectively attribution methodology has been selected as in 1.4. Edit first sentence to read "If*		
2.1	**Rewarding Improvement:** Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost	Adopt as presented	Consent

	benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.		
2.2	**Adjustment for Unpredicted Systemic Costs:** An end of year assessment should be conducted to evaluate the need to adjust for any systemic factors (e.g. the advent of new treatments, severe flu season) that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year. An adjustment can be made to the historic cost benchmark or an identified treatment can be temporarily carved out of the cost benchmark calculation.	Adopt with changes	Consent
2.3	**Supplemental Payments for Complex Patients:** An imperfect risk adjustment that does not account for hidden expenses associated with caring for socioeconomically complex patients may put some of the most vulnerable patients at greater risk for under-service and patient selection. To date, there is not a commonly accepted payment mechanism within shared savings programs to account for this, but payers should consider ways to financially incent provider organizations to care for the most vulnerable individuals.	Adopt with changes	Consent
2.3	*Kate McEvoy: I strongly support the rationales around need for supplemental payments for complex patients and believe that this merits additional discussion re current approaches. Washington state's total cost of care model is often cited by CMS as getting effectively at issues around social determinants.*		
2.4	**Retrospective Assessment for Risk Adjustment:** In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors.	Adopt as presented	Consent
2.5	**Cost Truncation and Service Carve Outs:** Truncating costs based on a percentile cutoff, and/or carving out select services, will eliminate any incentive to withhold required care after a catastrophic event or diagnosis in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.	Adopt with changes	Consent
3.1	**Eligibility Thresholds:** ACOs should only be able to share in savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or patient selection (as defined in the EAC charter and incorporated in payer-ACO contracts).	Adopt with changes	Consent
3.2	**Discrete Quality Payments:** Providing discrete incentive payments based on quality performance, irrespective of whether savings are achieved, will promote the provision of appropriate care and serve as a counter-balance against any incentive to inappropriately reduce costs.	Adopt as presented	Regular
3.2	*Mark Schaefer/Faina Dookh (PMO): The benefit of paying for quality alone should be balanced against the cost to consumers of weakening the incentive to manage costs. Committing to payment for quality alone without requiring corresponding savings may result in an overall increase in costs to the*		

	payer/employer. These costs will be passed on to the consumer in the form of higher premiums or cost-share. Higher premiums reduce access to coverage and higher cost-sharing reduces access to care.		
3.3	**Rewarding Quality Improvement:** ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement. To ensure that ACOs are not penalized for accepting new patients who may be more challenging to care for, year over year changes in ACO quality performance should be calculated using patients who have been continuously attributed to the ACO during the prior year and the performance year.	Adopt with changes	Consent
3.4	**Minimum Savings Rates (MSRs):** MSRs should not be utilized, or should be structured in a way that allows for deferred recoupment of savings. In the former case, any savings achieved should be shared with providers (assuming quality thresholds are met), thereby reducing the "all or nothing" aspect of reaching or not reaching an MSR. In the latter case, if an ACO demonstrates savings over a multi-year period which failed to meet an MSR in individual years, but which in combination are statistically significant, the ACO should be retroactively eligible to share in those savings.	Adopt as presented	Regular
3.4	*Mark Schaefer/Faina Dookh (PMO): While eliminating MSRs may make more funding available for investment in services, the notion that it will reduce under-service or patient selection seems much more tenuous than is the case for other proposed recommendations.*		
3.5	**Reinvestment of Non-Retained Savings:** When an ACO demonstrates cost savings, but is not eligible to receive the savings (either because the MSR was not met or because quality/performance targets were not met), the funds should be reinvested either (a) into the community's delivery system as a whole or (b) into the ACO (subject to a set of guidelines to ensure that funds are earmarked to support the ACO's future ability to deliver high performance, and are not used to finance incremental growth or compensation)	Table for further consideration	Regular
3.5	*Summary of Prior EAC Discussion: Retaining funds to invest in ACO improvement is beneficial, but this may pose economic challenges in particular for self-funded plans that would view this as a tax.*		
3.5	*Kate McEvoy: I am a fan of the idea of reinvestment of non-retained savings but do not believe that this would be realizable for Medicaid due to the fact that dedicated accounts are not favored. Also, there is no current vehicle through which Medicaid could make advance payments to ACOs for up-front costs.*		

3.5	*Mark Schaefer/Faina Dookh (PMO): While reinvesting savings may make more funding available for investment in services, the notion that it will reduce under-service or patient selection seems much more tenuous than is the case for other proposed recommendations.*		
3.6	**Advance Payments:** Providing ACOs with up-front funding dedicated to infrastructure will allow them to invest in the resources required to effectively manage care for defined populations. This incentive is especially important for smaller organizations or networks that are considering participation in MQISSP as ACOs. In addition, by improving ACOs' ability to lower costs through effective utilization management, this type of investment will reduce any incentives to lower costs through inappropriate methods that involve stinting on care or discontinuing patients.	Not yet considered	Regular
3.6	*Mark Schaefer/Faina Dookh (PMO): While providing advance payments to ACOs may make more funding available for investment in services, the notion that it will reduce under-service or patient selection seems much more tenuous than is the case for other proposed recommendations.*		
3.7	**Payment Distribution Methods:** To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel.	Adopt as presented	Consent
4.1	**ACO Internal Monitoring:** ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.	Adopt as presented	Regular
4.1	*Mark Schaefer/Faina Dookh (PMO): Should ACOs be required to establish an internal process to review patient appeals related to service denials by individual clinicians? Alternatively, should payers expand the scope of their appeals processes to encompass appeals related to service denials at the level of the ACO? In the latter case, perhaps this should be a separate recommendation.*		
4.2	**ACO Accreditation:** Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.	Adopt as presented	Consent
4.3	**Retrospective Monitoring Guidelines:** Each payer that enters into shared savings contracts should monitor for under-service and patient selection on an annual basis using a set of analytic methods that it establishes. At a minimum, the standard under-service and patient selection monitoring performed by payers should include:	Adopt with changes	Consent

	a) Under-service should be monitored by assessing utilization and total cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation. b) Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time. c) For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under-service payers should not necessarily disclose to providers which diagnoses will be monitored. d) Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.		
4.4	**Concurrent Monitoring: Nurse Consultant:** A nurse consultant (i.e. ombudsman) will play a key role as a "hub" of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA).	Table for further consideration	Regular
4.4	*Summary of Prior EAC Discussion: Concerns about expectations for this role - potentially need more than one person and will require training and skills that nurse consultants do not have today*		
4.4	*Mark Schaefer/Faina Dookh (PMO): Add "….and providers" to recommendation "one-stop source of information for consumers [and providers]"*		
4.5	**Concurrent Monitoring: Mystery Shopping:** Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population.	Table for further consideration	Regular
4.5	*Summary of Prior EAC Discussion: Concerns about feasibility - what relevant information is gathered at the time appointments are booked, and what sort of study would be required to generate a sufficient sample size?*		

4.5	*Mark Schaefer/Faina Dookh (PMO): Recommend rephrasing to suggest that payers should explore whether adapting existing, successful mystery shopping programs could be useful for the purpose of detecting patient selection on the basis of a factor other than insurance status. Given that an applicable methodology has not yet been cited or articulated, it is premature to suggest that any payer should employ this method of detection.*		
4.6	**Accountability: Corrective Action:** When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.	Adopt with changes	Regular
4.6	*Mark Schaefer/Faina Dookh (PMO): Additional language recommended, "The payer retains discretion to impose immediate termination in appropriate cases"; "In addition to CAPs and termination from contract, noncompliance can include but not be limited to: ACO education on how to operate in compliance with relevant standards; and suspension of termination of infrastructure payments or other payments due to the ACO."*		
4.6	*Kate McEvoy: I strongly support the recommendations on pp. 37-40 (re standards for retrospective monitoring, corrective action and publication of ACO arrangements), but would benefit from knowing more formally where the private payers are situated with respect to endorsing these.*		
4.7	**Retrospective Monitoring: Long-Term Analysis:** After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer analysis of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted	Adopt as presented	Regular

	ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.		
4.7	*Mark Schaefer/Faina Dookh (PMO): Replace "analysis" with evaluation "multi-payer [evaluation] of how value-based contracting is impacting service delivery"*		
4.8	**Accountability: Public Reporting:** Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include: a) Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which shared savings were withheld from an ACO. b) OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions.	Table for further consideration	Regular
4.8	*Summary of Prior EAC Discussion: The Council did not fully discuss this recommendation due to time constraints*		
4.8	*Mark Schaefer/Faina Dookh (PMO): Add language: "… any instances in which an ACO was placed on a corrective action plan and shared savings were withheld from an ACO."*		
	Adam Stolz/Katie Sklarsky (Chartis): Add a section to the recommendation concerning ACO reporting obligations: "ACOs participating in any payer's shared savings program should be required to publicly report information about their participating providers, leadership, quality performance, and shared savings, including payments (if any) received by the ACO and the total proportion of shared savings distributed among ACO participants and the total proportion used to support quality performance and program goals." [Excerpted in part from IRS summary of MSSP NPRM]		
4.9	**Peer Reporting:** The State should establish whistle-blower protections for employees or contractors of the ACO who report evidence of under-service, or of undue pressure from the ACO to under-serve.	Not yet considered	Regular
4.9	*Mark Schaefer/Faina Dookh (PMO): There appears to be no provision for whistleblowers to report an issue to the payer or to the state, with appropriate protections for the whistleblower. What does this look like in other areas, such as employee safety or sexual harassment? If the protection already exists but is not widely understood, additional ACO employee education should take place related to the protection.*		

5.1	**Consumer Communications: Scope:** Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.	Adopt with changes	Consent
5.2	**Consumer Communications: Accessibility and Consistency:** The type of information described in Recommendation #1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (i.e. at the time of insurance enrollment) and at the point of care (i.e. in the provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told.	Adopt as presented	Regular
5.2	*Mark Schaefer/Faina Dookh (PMO): Is the patient communicated with every time they visit?*		
5.3	**Consumer Communications: Content Development:** A work group should be convened to advise state agencies and payers on the content to be contained in the core messages described in Recommendation #2. This work group should recommend specific language to be incorporated in messages. The work group should be composed predominately of consumers, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.	Adopt as presented	Consent
5.4	**Provider Communications:** Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to lower the total cost of care and definitions of under-service and patient selection. This latter information should be communicated in a consistent manner to all providers.	Adopt as presented	Regular

5.4	*Mark Schaefer/Faina Dookh (PMO): Additional language: "… and definitions of under-service and patient selection and methods that are in place to guard against such, which will have a deterrent effect."*		